*Mississippi*CHIP

Change Form

*Please choose your preferred plan.

☐ UnitedHealthcare ☐ Magnolia Health

Indicates required field

MISSISSIPPI DIVISION OF MEDICAID

MississippiCHIP Enrollment
P.O. Box 23078
Jackson, MS 39225
Phone: 1-800-884-3222
Fax: 1-888-495-8169

www.medicaid.ms.gov/programs/mississippican/mississippican-chip-information/

Section 1 Personal Information	
***Beneficiary Name:**	
***Date of Birth: (mm/dd/yyyy)**	
***Medicaid ID # or *Social Security #**	
***Mailing Address:**	
***City/State:**	
County:	
Home or Cell Phone:	
Section 2 Primary Care Physician Information	
Do you have a primary care physician?	☐ YES ☐ NO
If yes, primary care physician name?	First_____Last_____
City:	
County:	
Facility Name:	
Physician Telephone Number:	

Comments:

Section 3 Your Signature	
***Signature:**	***Date:**

**For Office use only
Dating of Processing:

Received by:
Revised 12/12/2014